Branchville family Chiropractic

Today's Date: _____

PERSONAL DATA

Name: _____Age: _____ Date of Birth: _____
Both Parent's names: (if you are under 18) _____
Address: _____City: _____State/Zip: _____
Home phone: (____) _____ Business Phone: (____) _____
Cell Phone: (____)_____ E-mail: _____
Occupation: _____Employer: _____
Marital Status: ❑ S ❑ M ❑ D ❑ W Spouse/Partners name: _____
Names & Ages of Children: _____
Whom may we thank for referring you to our office? _____
I heard about your office from: (please circle all that apply) Internet Search Facebook Friend
Location Insurance Network Other: _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Branchville Family Chiropractic can address for you?

_____

_____

Are these concerns affecting your quality of life?

Work	❑Y	❑ N	Driving:	❑Y	❑ N	Sleep:	❑Y	❑ N
Relationships::	❑Y	❑ N	Walking:	❑Y	❑ N	Sitting:	❑Y	❑ N
Exercise/sports:	❑Y	❑ N	Eating:	❑Y	❑ N	School:	❑Y	❑ N

HEALTH CARE PRACTITIONER HISTORY

Have you had previous chiropractic care? ❑Y ❑ N Name of D.C: _____
How long under care? ❑ _____days ❑ _____ weeks ❑ _____ months ❑ _____ years
Date of last visit: _____ Why did you stop care?_____

Other Healthcare Practitioners:
Primary Physician _____
Date and reason of last visit:_____

Other specialists, healthcare professionals or alternative therapists regularly consulted :

_____

_____

FOR WOMEN

Are you pregnant? ❑Y ❑N Date of last menstrual period: _____
If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant.**
Signature: _____Date: _____
If pregnant, Due Date: _____Name of OBGYN or Midwife: _____

Health, Vitality and Chiropractic Care

The primary system in the body which coordinates health is the **nerve system**. The vertebrae, bones of the spinal column, surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called **vertebral subluxation**. Vertebral subluxation results in nerve malfunction due to vertebral/spinal misalignment. Vertebral subluxations can have physical, emotional and chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to in your life and how they may be related to your present spinal, nerve and health status and whether they may have caused vertebral subluxations to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system.

Please check where and how you were born. *(If you do not know, please skip to next question)*

❑ Home ❑ Hospital ❑ Natural ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

List any major falls, impact, sports injuries or broken bones. When?

_____

_____

Accidents: (Auto, Motorcycle, Bike etc) Please provide dates and severity of injuries (if any)

_____

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N If yes, state reason and dates:

_____

_____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Rate your current level of *personal stress* in your life: ❑ None ❑ Low ❑ Moderate ❑ High
Rate your current level of *relationship stress* in your life: ❑ None ❑ Low ❑ Moderate ❑ High
Rate your current level of *financial stress* in your life: ❑ None ❑ Low ❑ Moderate ❑ High
Rate your current level of *health stress* in your life: ❑ None ❑ Low ❑ Moderate ❑ High
Rate your current level of *family stress* in your life: ❑ None ❑ Low ❑ Moderate ❑ High

Rate the level of *childhood stress* you experienced: ❑ None ❑ Low ❑ Moderate ❑ High
Do you feel that you have healthy coping strategies for life stress: ❑Y ❑ N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ❑ Y ❑ N If yes, did you have a reaction? ❑ Y ❑ N ❑ Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please explain:_____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N

If yes, please list: _____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter): _____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

Please compete the following rating your self-assessed quality of life. On a scale of 1 to 10 with 1 being TERRIBLE, and 10 being OPTIMAL circle the number corresponding to your experience.

Overall Quality of Life	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10
Energy Levels	1	2	3	4	5	6	7	8	9	10
Thinking/Concentration	1	2	3	4	5	6	7	8	9	10
Activity Level/Exercise	1	2	3	4	5	6	7	8	9	10
Coordination	1	2	3	4	5	6	7	8	9	10
Digestion / Bowel (BM)	1	2	3	4	5	6	7	8	9	10
Immune System Function	1	2	3	4	5	6	7	8	9	10
Breathing	1	2	3	4	5	6	7	8	9	10
Posture	1	2	3	4	5	6	7	8	9	10

Rate your diet on a scale of 1 – 10 with 1 being nothing but fast and processed foods and 10 being a diet consisting primarily of organic fruits and vegetables, whole grains and lean grass fed meats: _____
Do you exercise regularly? If yes,: How often? What type of exercise? _____

_____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? (Low carb, vegetarian/vegan, etc) _____

_____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: *(Check all that apply)*

- ❒ Relief of a symptom or problem
- ❒ Relief and Prevention of a symptom or problem
- ❒ Healthier spine and nerve system
- ❒ Optimal health on all levels
- ❒ Other _____

The information I have provided on this case history form is true and accurate to the best of my knowledge. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon. I give the doctors at BFC permission to render care to me today.

Name: (printed) _____ Date: _____

Signature: _____

Signature of Parent (for minor): _____